

**INSTRUCTIONS FOR COMPLETION OF COBRA NOTICE  
LOCAL EMPLOYER GROUP 92000**

**COBRA NOTICE — Completed by employer. Please print or type.**

- a. To the Family of** — Indicate the employee’s full name and current address of record. Notice must be mailed to meet legal requirements for the notification of dependents, so the address is essential. If the Notice is being sent to a specific dependent, add an attention line with his/her name.
- b. Employee’s Social Security Number**
- c. Notice Date** — Date COBRA is signed by the Certifying Authority.
- d. Employer Name** — Provide the name of your organization, *e.g.*, Roselle Township, Totowa Board of Education, etc.
- e. Group Number** — List your State Health Benefits Group Numbers, *e.g.*, 92-0048-0.
- f. Employee Type** — Indicate if the employee is a 10 or 12-month employee., *i.e.*, they have a contract of employment covering ten or twelve months.
- g. COBRA Event** — The event that caused the loss of coverage and entitled the employee and/or dependent(s) to continuation of coverage under COBRA. Choose from the following:
  - 1) retirement;
  - 2) termination other than retirement, *i.e.*, resignation, lay off, firing;
  - 3) reduction in hours;
  - 4) privatization;
  - 5) leave of absence;
  - 6) death of employee;
  - 7) divorce or separation;
  - 8) dependent ineligibility — age 23;
  - 9) dependent ineligibility — marriage;
  - 10) dependent ineligibility — moved out of household; or
  - 11) MEDICARE entitlement, *i.e.*, employee seeks MEDICARE as primary insurance.
- h. Date of COBRA Event** — Date of the event listed in **g** above. This is not the last date of coverage; it is the date of the event above that will cause coverage to end.
- i. COBRA Continuation Term** — Number of months of eligibility for COBRA coverage. This is generally 18 months for reasons 1 - 5 in **g** above and 36 months for reasons 6 - 11 in **g** above. Time spent on a leave of absence with pre-paid benefits must be subtracted from the COBRA term. If the employee has a Social Security Administration approved disability award, he/she is entitled to 29 months of COBRA coverage. A copy of the SSA approval letter must be sent with the COBRA application.
- j. Current Coverage** — Mark the type and level of coverage held by the employee at the time of the COBRA event. If HMO, list the name and number of the HMO. Only mark the Prescription Drug coverage if your location belongs to the State Prescription Program.
- k. Last Date of Coverage** — Indicate the last date under the active coverage of the employee for each of the plans listed in **j** above. This date will always be the last day of the month. For COBRA events 1 - 5 in **g** above, use the chart on page 197 of the *Pensions and Benefits Administration Manual* to determine the date. For COBRA events 6, 7, 9, and 10, the last date of coverage is the end of the month in which the event occurred. For event 8, the last date of coverage is December 31 of the year in which the child turned age 23. For COBRA event 11, the last date of coverage is the MEDICARE effective date of coverage.
- l. Name of Employer Contact Point and Phone Number** — Name and phone number of individual who should be contacted if there are questions about the COBRA Notice.
- m. Signature of Certifying Authority** — Signature of individual authorized to certify that information on the COBRA Notice is correct. *No stamped signatures, please.*

Mail to the employee/dependent the COBRA Notice/Application, a COBRA rate chart, and a copy of the instructions on the reverse side of this page. Hand delivery to the employee does not meet the legal requirement to notify family members covered under the group coverage. Keep a copy of the Notice for your files.

**CONTACT THE COBRA SECTION OF THE STATE HEALTH BENEFITS  
BUREAU, DIVISION OF PENSIONS AND BENEFITS, IF YOU HAVE ANY  
QUESTIONS REGARDING THESE INSTRUCTIONS OR IF YOU NEED  
ADDITIONAL BLANK COBRA NOTICES OR APPLICATIONS.**

**INSTRUCTIONS FOR COMPLETION OF COBRA APPLICATION  
LOCAL EMPLOYER GROUP 92000**

Please read the COBRA Notice on the opposite side of the COBRA Application before you begin to complete the application.

**COBRA APPLICATION — Completed by applicant. *Please print or type.***

**SECTION 1 — APPLICANT INFORMATION**

This section must be completed by the applicant for the COBRA coverage, that is, the individual who will be the insured person. Provide all requested information and enter only one number or letter per block. For relationship to the employee, enter self, spouse, or child.

**SECTION 2 — CHANGE INFORMATION**

This section is to be completed **ONLY** if you are already enrolled for COBRA coverage and are changing that coverage.

**SECTION 3 — EMPLOYEE INFORMATION**

This section only has to be completed if the applicant is/was a dependent of the employee. If the employee is the applicant, the section is left blank. *Note:* the employee does not have to continue coverage to allow a dependent to enroll.

**SECTION 4 — COVERAGE ELECTION**

PLEASE READ THE INSTRUCTIONS ON THE ACCOMPANYING RATE CHART AT THIS TIME. Indicate the coverage that you are electing by marking the appropriate block and entering the monthly premium rate from the chart that accompanied your COBRA Notice. You may only select the type of coverage you had as an active employee, e.g., health and/or prescription drug. If you had health coverage you may select any health plan offered.

If eligible, you may select any health plan offered providing you live within the geographic limits covered by the plan you select. Contact your former employer or the health plan to verify their coverage area. The Traditional Plan has no geographic restrictions — it is good anywhere in the world.

If you select an HMO you must enter the name of the HMO.

You cannot cover dependents under COBRA that you did not cover at the time of the termination of your active benefits. For example, if you had Husband & Wife coverage before termination you may only select Husband & Wife or Single coverage at this time, not Family or Parent-Child coverage. An exception is if the qualifying event increasing your family, e.g. birth, adoption, marriage, was within 60 days of your COBRA election.

**SECTION 5 — HEALTH PROVIDER INFORMATION**

If you select either NJ PLUS or an HMO, you must enter your doctor’s HMO or NJ PLUS ID#.

*Note:* Failure to provide this information will delay enrollment with the insurance carrier.

**SECTION 6 — SPOUSE AND DEPENDENT INFORMATION**

If you selected any coverage other than Single, you must enter the dependents you want covered on your plan. If your dependent children are adopted, foster or stepchildren, enter the appropriate code. Otherwise, enter “C” in the block on the far right. Federal law requires that a Social Security Number be provided for all covered dependents. If you selected coverage in an HMO or NJ PLUS, enter each dependent’s primary care physician ID number in the appropriate block.

**SECTION 7 — SSA DISABILITY EXTENSION**

If you have a disability that has been approved by the Social Security Administration, you may be entitled to an extension of your COBRA coverage for up to 29 months. You must attach a copy of the SSA Award letter approving the disability to obtain this benefit.

**SECTION 8 — CERTIFICATION AND SIGNATURE**

The application must be signed by the applicant. The legal guardian may sign in the case of a minor child. Please read the certification carefully because it will have a direct impact on your continuation of coverage.

**UNSIGNED, UNDATED OR INCOMPLETE APPLICATIONS CANNOT  
BE PROCESSED AND WILL BE RETURNED TO THE APPLICANT.  
ADDITIONALLY, THE COBRA NOTICE PROVIDED TO YOU BY  
THE EMPLOYER MUST BE SUBMITTED WITH THE APPLICATION.**